Witness Name: Professor
Mohammad Khurshid
Statement No.: WITN5311001
Exhibits: None
Dated: March 19, 2021

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF PROFESSOR MOHAMMAD KHURSHID

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 25 January 2021.

I, Mohammad Khurshid, will say as follows: -

Section 1: Introduction

1. **Please set out your full name, address, date of birth and professional qualifications.**

1.1. Name: Mohammad Khurshid

1.2. Date of Birth: GRO-C 1945

1.3. Address: GRO-C

1.4. Office Address: IBN E ZUHR Building, The Aga Khan University, Stadium Road, P.O. Box 3500, Karachi 74800, Pakistan

1.5. Telephone (Res): GRO-C (Off): 4930051 Ext: GRO-C

1.6. Email: GRO-C

1.7. Educational background:

1967	M.B.B.S	University of Karachi Dow Medical College, Karachi
1970	Diploma in Pathology	Royal Colleges of Physicians and Surgeons United Kingdom
1974	MRC Pathology (Haematology)	Royal College of Pathologists United Kingdom
1986	FRC Pathology (Haematology)	Royal College of Pathologists United Kingdom
2001	F.C.P.S	Royal College of Physicians and Surgeons Pakistan
2003	F.R.C.P.	Royal College of Physicians London
2004	F.C.B.P.S.	Bangladesh College of Physicians and Surgeons Bangladesh

1.8. Professional background:

May 2012 - Present	Founding Chair Clinical, Department of Oncology and Haematology
Jan 2009-Present	Professor, Haematology, Department of Pathology and Microbiology, Aga Khan University Hospital, Karachi

Aug 2003 - Jan 2009	Dean, Medical College, The Aga Khan University
Jan 2000 - Jul 2003	Medical Director and Associate Dean, Clinical Affairs, The Aga Khan University Hospital Karachi
Feb 1985 - Dec 2000	Chairman, Department of Pathology and Director Clinical Laboratories, The Aga Khan University Hospital
Feb 1989 - present	Haiderali R. Charania Professor, Pathology and Medicine Consultant Haematologist, The Aga Khan University Hospital
Feb 1985 - Feb 1989	Associate Professor, Department of Pathology and Medicine and Consultant Haematologist, The Aga Khan University Hospital
Nov 1977 - Nov 1979	(Sabbatical). Associate Professor, Department of Haematology, King Abdul Aziz University Hospital, Jeddah, Saudi Arabia
May 1975 - Feb 1985	Consultant Haematologist, West Glamorgan Health Authority, West Glamorgan, UK
Jun 1971 - Apr 1975	Senior Registrar, Department of Haematology, University Hospital of Wales and Welsh National School of Medicine, Cardiff, UK.
Jan 1969 - May 1971	Senior House Officer and Registrar, Department of Pathology and Haematology, Whipps Cross Hospital, Leytonstone, London E11

Jun 1968 - Dec 1968	House Physician, Princess Alice Hospital, East Bourne, Sussex

1.9. Professional societies affiliation:

1.9.1 British Society of Haematology, United Kingdom.

1.9.2. International Society for Haematology, IAH Asia Division

1.9.3. Pakistan Association of Pathologists.

1.9.4. Pakistan Medical Research Society.

1.9.5. Pakistan Oncology Co-operative group.

1.9.6. Pakistan Society of Haematology.

1.9.7. Pakistan Academy of Medical Sciences.

2. Please set out your employment history including the various roles and responsibilities that you have held throughout your career, as well as the dates.

2.1. Employment history as above and responsibilities included:

2.1.1. Clinical and laboratory haematology

2.1.2. Medical education and administration

3. Please set out your membership, past or present, of any committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference, including the dates of your membership and the nature of your involvement. Please ensure your answer addresses your involvement with the UKHCDO.

3.1. None.

4. **Please confirm whether you have provided evidence to, or have been involved in, any other inquiries, investigations, criminal or civil litigation in relation to human immunodeficiency virus ("HIV") and/or hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob disease ("vCJD") in blood and/or blood products. Please provide details of your involvement and copies of any statements or reports which you provided.**

4.1. None.

Section 2: Decisions and actions of the Swansea Haemophilia Centre

5. **Please describe how the care of patients with bleeding disorders was organised at the Swansea Haemophilia Centre ('the Centre') during the time you worked there. Please provide an account of the history of the provision of care of patients with bleeding disorders, its establishment and its activities during this time.**

5.1. I was appointed as a Consultant Haematologist by the West Glamorgan Health Authority based at Morriston hospital. I joined in May 1975 and left in December 1984. To take up my present position, during this time I also took unpaid leave to work in Saudi Arabia from November 1977 to November 1979. During this time a locum Haematologist Dr. Majumdar was appointed.

5.2. On my arrival to West Glamorgan in May 1975 and with three general hospitals (Morriston, Neath, and Singleton), My first priority was to reorganize the laboratories and introduce and start clinical Haematology with Outpatient and Inpatient in all three hospitals. Morriston was earmarked for Coagulation and Laboratory services initiated and set up with the help of Cardiff to support a Haemophilia Centre etc. and then with Dr. Bloom's blessings and advice Morriston was initially designated as sub-centre with Cardiff as the main centre. Patients resident in West Glamorgan were invited to register. I was already familiar with most patients as they would have been seen and

attended to in Cardiff. Cryoprecipitate and platelets were supplied by the transfusion centre and factor concentrates were sourced through Cardiff. Treatment and management was done according to accepted guidelines and practices. Second opinions and guidance was also sought from Dr. Bloom when necessary. Dr. Ismail joined us in 1983 and contributed to the effort of managing the patients and supervision of the centre.

6. **Please identify senior colleagues at the Centre concerned with the care of patients with bleeding disorders and their roles and responsibilities during the time that you worked there.**

6.1. Was single handed, supported by one junior staff and coordination with Prof. Bloom in Cardiff

7. **Please describe:**

   a. **Your role and responsibilities at the Centre and how, if applicable, this changed over time.**

7.1(a)

i. Initial start-up with the establishment of coagulation laboratory services – technical laboratory, staff training with the help and assistance of Cardiff.

ii. Starting the clinical services at Morriston hospital with the help of Junior Medical + nursing staff.

iii. Designation as a sub-centre and registration of patients.

iv. Coordination with Cardiff regarding patient care, supplies of Factor concentrates and Welsh transfusion services for Cryoprecipitate and platelets.

v. Ensuring smooth running of the laboratory and clinical services according to the accepted guidelines and norms.

vi. Left towards the end of 1984.

b. Your work at the Centre insofar as it involved the care of patients with bleeding disorders and/or patients infected with hepatitis and/or HIV in consequence of infected blood or blood products.

7.1(b) I do not recollect any such patients, if any they would be dealt with in conjunction with Cardiff.

8. Approximately how many patients with bleeding disorders were under the care of the Centre when you began work there and over the years that followed? (If you are able to give exact rather than approximate figures, please do so).

8.1. This was a newly established centre and the initial patients were those being managed in Cardiff and resident in West Glamorgan. It is difficult to remember the exact numbers.

9. To the best of your knowledge, what decisions and actions were taken, and what policies were formulated by the Centre, regarding the selection, purchase and use of blood products (in particular factor concentrates) during the time that you worked there? In addressing this issue, please answer the following questions:

9.1 The products used for treating the patients included: a) platelets transfusions, b) fresh frozen plasma. Platelets, fresh frozen plasma and cryoprecipitate were supplied by Welsh Transfusion Centre.

9.2. Factor Concentrates were purchased commercially; the decision was made by Cardiff (Prof. Bloom); I had no involvement in the selection or purchase of these. We would give our estimated needs to Cardiff. Mr. Munroe the scientific Officer overseeing the coagulation laboratories would have more details.

a. How, and on what basis, and by whom, were decisions made about the selection and purchase of blood products?

9.1(a) Cardiff Prof. Bloom.

b. What (if any) other bodies or organisations or individuals (e.g. other centres in the same region, or the Regional Health Authority) were involved in the arrangements for the selection, purchase or use of blood products?

9.1(b) I don't know of any

c. What were the reasons or considerations that led to the choice of one product over another?

9.1(c) The criteria were set by Cardiff and would gradually evolve in view of the recognized hazards and safety indicators prevailing at that time.

d. What role did commercial and/or financial considerations play?

9.1(d) They were not primary but I understand that they did play a part in Dr. Bloom's decisions to minimize cost.

e. What if any involvement did you have?

9.1(e) I had no involvement.

f. What products or treatments were generally used for treating (i) patients with severe haemophilia A; (ii) patients with moderate haemophilia A; (iii) patients with mild haemophilia A; (iv) patients with haemophilia B; (v) patients with von Willebrand's disease?

9.1(f)

i. Severe Haemophilia A: Factor VIII Concentrates

ii. Moderate Haemophilia: Factor VIII Concentrates

iii. Mild Haemophilia: Factor VIII Concentrates, Cryoprecipitate, DDVP

iv. Haemophilia B: Factor IV Concentrates

v. Von Willebrand's: Cryoprecipitate, DDVP

10. What particular products were used for treating patients at the Hospital, over what period of time and for which categories of patients?

10.1. I do not remember specific names, but Dr. Ismail mentions specifics and they must have got them from old records.

11. What was the relationship between the Centre and the pharmaceutical companies manufacturing/supplying blood products? What influence did that relationship have on the Centre's decisions and actions? In answering this question, please describe the kinds of interactions and communications (such as visits from sales representatives) you had with pharmaceutical companies which supplied factor concentrates.

11.1. The decision for selection and purchase was made by Prof. Bloom. I was not involved or consulted. Pharmaceutical representatives would visit me to appraise us of development and availability of various products, but they were also explained the system of selection and purchase through Cardiff.

12. If applicable, please explain your involvement in making arrangements for the purchase of commercial products from pharmaceutical companies. Pages 40, 53 and 161 of the transcript of Dr. Al Ismail's oral evidence may assist you, as well as BAYP0000029_014.

12.1. Up to my presence in Swansea, I had no involvement in purchase or selection of these products.

13. If the responsibility for the selection and purchase of blood products lay with an organisation other than the Centre, please specify which organisation and provide as much information as you can about its decision-making.

13.1. Cardiff centre, Prof. Bloom. I do not know his criteria but always assumed it was based on safety, quality, availability and cost impact.

14. Please describe your relationship/the Centre's relationship with the local Regional Transfusion Centre. Please explain whether the Regional Transfusion Centre supplied the Centre with cryoprecipitate and with NHS factor concentrates and whether (and if so to what extent and with what frequency) there were shortages or other difficulties in obtaining sufficient supplies. Please confirm whether the Regional Transfusion Centre had any involvement in supplying commercial factor concentrates or whether those were obtained from the pharmaceutical companies directly.

14.1. Good working relationship with Welsh Transfusion services. They supplied Cryoprecipitate but not NHS Factor VIII or Commercial Concentrates. I do not remember any shortages.

15. What alternative treatments to factor concentrates were available in the 1970s and 1980s for people with bleeding disorders?

15.1 Bleeding disorders which include quantitative and qualitative platelets defects and coagulation factor deficiencies.

i. Local Measures

ii. Antifibrinolytic drugs - Transamine

iii. DDVP (Desmopressin)

iv. Fresh Frozen Plasma

v. Cryoprecipitate

16. What was the Centre's policy and approach as regards:

a. The use of cryoprecipitate for the treatment of patients with bleeding disorders? Did that policy and approach change over time and, if so, how?

16.1(a) As the concentrates became available because of the ease of use, storage, availability and potency, the tendency was to use concentrates but I have seen the 1983 consumption figures (sent by you) and it shows we were still using Cryoprecipitate and NHS Concentrates.

b. Home treatment? When was home treatment introduced?

16.1(b) I do not recall the exact time table but would be dependent on patient circumstances and increased availability of concentrates.

c. Prophylactic treatment? To what extent and when was treatment provided on a prophylactic basis? Did the policy and approach change over time and if so how?

16.1(c) I cannot recall exact numbers, but prophylactic treatment would be reserved for chronic and recurrent bleeds.

17. To what extent, and why, were patients with mild or moderate bleeding disorders treated with factor concentrates?

17.1. I do not recall if we did

18. What was the Centre's policy and approach in relation to the use of factor concentrates for children? Did the policy and approach change over time and if so how?

18.1. Till 1984 - No - Again I cannot recall there was a policy or it changed.

18.2. No specific policy same guidelines as for adults till 1984.

19. At pages 50, 51 and 56 of the transcript of his oral evidence, Dr. Al-Ismail states that both you and Dr. Al-Ismail followed the advice of Professor Bloom in terms of treatment of patients. Dr. Al-Ismail elaborates that you were in regular contact with Professor Bloom and that he was 'very available' to you (page 51, line 17). Do you agree with Dr. Al-Ismail's comments? Is there anything further that you would like to add?

19.1. Dr. Bloom was my mentor and teacher. He encouraged and supported the move to start a facility in Swansea for the convenience of the patients resident in this area. We were initially designated as sub-centre to Cardiff and had all the support. I had good access to Dr. Bloom and the facilities available in Cardiff.

20. At pages 65 - 66 of the transcript of his oral evidence, Dr. Al-Ismail refers to the Haemophilia Treatment Policy Guidelines dated May 1983 (CVHB0000002_006) and states that if this document had been sent to Swansea, it would have been sent to you. Do you recall ever seeing this document in 1983?

20.1. I must have seen the documents if it was sent to me but I have no recall of this now.

Section 3: Knowledge of, and response to, risk

Hepatitis

21. When you began work as a consultant haematologist at the Centre, what was your knowledge and understanding of:

a. The risks of the transmission of hepatitis (including hepatitis B and NANB hepatitis/hepatitis C) from blood and blood products?

21.1(a) As a Haematologist involved with blood transfusion and laboratories and user of Blood and blood products, I was very much aware of this risk and necessity to screen blood products and that no screening test was 100%. That there was always a risk especially in those who were on concentrates therapy with blood/blood products or received products made from pooled sources.

b. The nature and severity of the different forms of blood borne viral hepatitis?

21.1(b) Yes ranging from asymptomatic states to fulminant hepatic failure and long-term sequelae of cirrhosis and cancer.

22. What were the sources of your knowledge? How did that knowledge and understanding develop over time?

22.1. Medical Journal and literature, symposia and meetings specific to hepatitis communication from professional societies. Personal observations (This was the pre-internet days). The development and understanding were related to time. When I first began training in 1969 we had Serum Hepatitis and infective hepatitis – Serum being related to blood transfusion then came the discovery of Australia antigen and demonstration of Hepatitis B antigen as a cause for Serum Hepatitis.

22.2. Hepatitis: Tests for Hepatitis B antigen were developed and blood screening initiated

22.3. Later, Serum hepatitis was classified as B or Non-A/ Non-B – But no markers for Non-A / Non-B. Later tests for hepatitis C antigens were developed and Blood screened for B and C antigens - Now nucleic acid testing, but still not 100% exclusion.

23.4. At the same time virus neutralization and Deactivation techniques were introduced in the production of factor concentrates.

23. What, if any, actions did you and/or the Centre take to reduce the risk to patients of being infected with hepatitis (of any kind)?

23.1. Firstly, it was assumed that all blood/blood products had been screened with the available tests and methodology and approved by the regulating authorities.

HIV and AIDS

24. What was your knowledge and understanding of HIV (HTLV-III) and AIDS and in particular of the risks of transmission from blood and blood products during your time working at the Hospital? What were the sources of your knowledge? How did your knowledge and understanding develop over time?

24.1. Initially from Communications from Oxford Haemophilia centre and Medical literature and then Dr. Bloom who I think was overseeing the effort to reduce/eliminate risk at that time. Again, over a period of time the Medical Literature, Prof societies etc. a lot of new knowledge came through including later establishment of Laboratory test for screening blood products, realisation that pooled donations from professional donors used in producing factor concentrates were implicated and leading to virus inactivated products and then later recombinant products.

25. How and when did you first become aware that there might be an association between AIDS and the use of blood products?

25.1. I don't recall, but probably from the Centre from Oxford as seen in your exhibits and Dr. Bloom.

26. What, if any, enquiries and/or investigations did you and/or the Centre carry out or cause to be carried out in respect of the risks of transmission of HIV or AIDS? What information was obtained as a result?

26.1. We did not carry out any enquiries/investigations but probably cooperated with National enquiries guidelines or data.

Response to risk

27. Did you and/or your colleagues at the Centre take steps to ensure that patients were informed and educated about the risks of hepatitis and HIV? If so, what steps? What information was provided to patients, and when, about such risks?

27.1. I do not recall but the General policy was to keep our patient population well informed and counselled. The Haemophilia patients generally were well informed and educated. They also had access in Haemophilia society information the risks explained were pertinent to that time mainly hepatitis B+C and then HIV and also the measures taken to reduce these risks.

28. What, if any, actions did you and/or the Centre take to reduce the risk to your patients of being infected with HIV? What changes (if any) did you make to the way in which patients were treated?

28.1. I do not recall, but there is a treatment guideline which was circulated and we followed that, using DDVP, Cryoprecipitate and Factor VIII NHS Concentrates.

29. Did the Centre continue to use factor concentrates to treat patients, after becoming aware of the possible risks of infection with HIV? If so, why?

29.1. Post 1984 I have no knowledge. I cannot recall.

30. Did you or your colleagues at the Centre revert to treatment with cryoprecipitate for some or all of the patients in response to the risk of infection? If so, when and how was it determined which patients would be offered a return to cryoprecipitate and which would not? If not, why not?

30.1. I do not recall, but we probably did, except inhibitor patients.

31. When did the Centre begin to use heat-treated factor products and for which categories of patients? Please set out what steps were taken to obtain heat treated products. Please also set out whether steps were taken to recall any stores of unheated products which patients had.

31.1. I do not recall the exact dates or when the heat-treated concentrates became available but as a Centre we would follow all the policy/guidelines. It was Cardiff who managed the purchase and supply. I do not recall what exact steps were taken to recall the unheated products, but they were probably recalled.

32. Do you recall having any conversations with Dr. Al-Ismail or Professor Bloom about the move to heat-treated products?

32.1. I do not but must have discussed with them both and also Dr. Bloom was the procurer of concentrates for Moriston.

33. Looking back now, what decisions or actions by you and/or by the Centre could and/or should have avoided, or brought to an end earlier, the use of infected blood products?

33.1. We followed all the guidelines and process and heeded to alarms when raised. Perhaps in retrospect not only us but everyone should have adhered to single donor products where possible.

34. What actions or decisions or policies of other clinicians or other organisations, within your knowledge, played a part in, or contributed to,

the scale of infection in patients with bleeding disorders? What, if anything, do you consider could or should have been done differently by these others?

34.1. The Oxford Haemophilia Centre were diligent and gave necessary guidelines and helpful advice; I believe the drug regulation authorities should have been more stringent on the pharmaceuticals.

Section 4: Treatment of patients at the Centre

Provision of information to patients

35. **What information did you provide or cause to be provided (or was, to your knowledge, provided by others) to patients at the Centre with a bleeding disorder about the risks of infection in consequence of treatment with blood products (in particular, factor concentrates) prior to such treatment commencing? Please detail whether, and if so, how this changed over time.**

35.1. General information to patients and attendants at that time include the general side effects, and Hepatitis B and Non-A / Non-B, Hepatitis C. In the 1983-84 period the probable risk of HIV was also explained, the safety of various product was also provided.

36. **What information did you provide or cause to be provided (or was, to your knowledge, provided by others) to patients about alternatives to treatment with factor concentrates? Please detail whether, and if so, how this changed over time.**

36.1. For mild haemophilia and Von Willebrand's disease and Non-concentrates disease – DDVP and Cryoprecipitate. For severe haemophilia Cryoprecipitate, NHS Concentrates and later heat-treated concentrates.

HIV

37. When did you first discuss AIDS or HIV (HTLV-III) with any of your patients?

37.1. When awareness, suspicion arose of HIV/AIDS and Blood products transmission – This was probably 1983-84.

38. How many patients at the Centre were infected with HIV? How and when did you learn that patients under your care/the Hospital's care had been infected with HIV?

38.1. I do not recall any specific patient but if there was any I would refer them to Cardiff.

39. Please describe the Centre's process for HIV testing, including pre-test and post-test counselling.

39.1. This was after 1984.

40. Please describe the arrangements that were made for the testing of the patients. Were they tested without their knowledge? What if any arrangements were made at the Centre for pre-test counselling?

40.1. This was after 1984.

41. How and when were patients told that they had been, or might have been, infected with HIV? What if any involvement did you have in this process?

41.1. This was after 1984.

42. What information was given to them about the significance of a positive diagnosis? Were patients told to keep their infection a secret?

42.1. I do not recall.

43. Was work undertaken at the Centre to establish the time period during which patients seroconverted? If so, please describe what work was done and what if any conclusions were reached.

43.1. I do not recall.

NANB Hepatitis/Hepatitis C

44. How many patients at the Centre were infected with hepatitis C in consequence of their treatment with blood products?

44.1. I do not recall the numbers. The test for Hepatitis C was probably not available then and diagnosis would have been clinical and Hepatitis B tests

45. Were patients infected with hepatitis C informed of their infection and if so, how and by whom? What information was provided to infected patients about the infection, its significance, prognosis, treatment options and management? What if any involvement did you have in this process?

45.1. If suspected, I would inform them and refer to our Gastroenterology team – I do not recall any patient.

46. When did the Centre begin testing patients for hepatitis C and over what period of time were such tests first carried out? Please describe the Hospital's process for HCV testing, including pre-test and post-test counselling. What involvement did you have in this process?

46.1. Probably after 1984.

47. What information was provided to patients infected with hepatitis C about their infection, its significance, prognosis, treatment options and management?

47.1. Probably after 1984.

48. When a test for HCV became available, what if any steps were taken by the Centre and/or by you to ensure that all patients who had received blood products were traced and invited to be tested?

48.1. Probably after 1984.

Delay

49. Were the results of testing for HIV and hepatitis C notified to patients promptly, or were there delays in informing patients of their diagnosis? If there were delays in informing patients, explain why.

49.1. Probably after 1984.

Consent

50. How often were blood samples taken from patients attending the Centre and for what purposes? What information was given to patients about the purposes for which blood samples were taken? Were patients asked to consent to the storage and use of the samples? Was their consent recorded and if so, how and where?

50.1. Samples were taken for laboratory testing related to management and treatment. ____ they were not stored.

51. Did the Centre have a bank of stored samples? If so, was that storage undertaken with patients' knowledge and consent?

51.1. No bank and samples not stored.

52. Were patients under your care/under the Centre's care treated with factor concentrates or other blood products without their express and informed consent? If so, how and why did this occur? What was your approach to obtaining consent to treatment? Was their consent recorded and if so, how and where?

52.1. Patients were informed. No patient was treated against their wishes, explanation and counselling was always provided re treatment plans.

53. Were patients under your care ever tested for HIV or hepatitis or for any other purpose without their express and informed consent? If so, how and why did this occur? What was your approach to obtaining consent for testing? Was their consent recorded and if so, how and where?

53.1. No - Also tests not available then except of Hepatitis B.

PUPS

54. Please detail all decisions and actions taken at the Hospital by you or with your involvement with regard to a category of people referred to as 'previously untreated patients' (PUPS).

54.1. Not involved. New and untreated patients up to 1984 would be dealt with according to prevailing standard guidelines.

Treatment of patients who had been infected with HIV and/or Hepatitis

55. How was the care and treatment of patients with bleeding disorders and HIV/AIDS managed at the Centre? In particular:

a. **What steps were taken to arrange for, or refer patients for, specialist care?**

b. **What treatment options were offered over the years?**

c. **What information was provided to patients about the risks and benefits of specific treatments and about side effects?**

d. **What follow-up and/or ongoing monitoring was arranged in respect of patients who were infected with HIV?**

55.1. Not involved. No example up to 1984. Clinical suspected cases if any would be referred to Cardiff

56. **How was the care and treatment of patients with bleeding disorders and hepatitis C managed at the Hospital? In particular:**

a. **What steps were taken to arrange for, or refer patients for, specialist care?**

b. **What treatment options were offered over the years?**

c. **What information was provided to patients about the risks and benefits of specific treatments and about side effects?**

d. **What follow-up and/or ongoing monitoring was arranged in respect of patients who were infected with hepatitis C?**

56.1. No specific examples. If liver damage was suspended referring to G.I. Team in the hospital. Points a-d - This is all relevant to post 1984.

57. What arrangements, if any, were made to provide patients infected through blood products with counselling, psychological support, social work support and/or other support?

57.1. Relevant to post 1984.

58. Did the Centre receive funding from the Department of Health and Social Security or from any other source to help with the counselling of patients infected with HIV?

58.1. Relevant to post 1984.

59. What (if any) difficulties did you/the Hospital encounter in obtaining sufficient funding for the treatment of people who had been infected with HIV and/or hepatitis C?

59.1. Relevant to post 1984.

60. What if any involvement did you or your patients have with clinical trials in relation to treatments for HIV and/or hepatitis? Please provide full details.

60.1. Relevant to post 1984.

Records

61. What was the Centre's policy with regards to recording information on death certificates when a patient had been infected with HIV or hepatitis?

61.1. Relevant to post 1984.

62. What were the retention policies of the Centre in regards to medical records during the time you were practising there?

62.1. I am not aware of the retention policies of the medical records.

63. Did you:

a. Maintain separate files for some or all patients? If so, why; where were those files located; and where are those files now?

b. Keep records or information (e.g. information being used for the purpose of research) about any of your patients at your home or anywhere other than the Centre? If so, why, what information and where is that information held now?

63.1. No.

Research

64. Please list all research studies that you were involved with as a consultant haematologist at the Centre (or any other relevant positions of employment) insofar as relevant to the Inquiry's Terms of Reference, and please:

a. Describe the purpose of the research.

b. Explain the steps that were taken to obtain approval for the research.

c. Explain what your involvement was.

d. Identify what other organisations or bodies were involved in the research.

e. State how the research was funded and from whom the funds came.

f. **State the number of patients involved.**

g. **Provide details of steps taken to inform patients of their involvement and to seek their informed consent.**

h. **Provide details of any publications relating to the research.**

64.1. None.

65. The Inquiry understands that the various research studies undertaken at the Centre, or that you otherwise contributed to or were involved in or provided data for, included or may have included an article published in 2001: "Treatment of haemophilia in the United Kingdom 1981-1996" (HSOC0023510). Please set out what you recall of this research study and explain what involvement you had in them.

65.1. Not involved.

66. Please provide the same details in relation to any other studies in which you were involved or articles you have published, insofar as relevant to the Inquiry's Terms of Reference, including the enclosed article [OXUH0001751_003].

66.1. None.

67. Were patients involved in research studies without their express consent? If so, how and why did this occur?

67.1. Not applicable.

68. Was patient data (anonymised, de-identified or otherwise) used for the purpose of research or shared with third parties without their express

consent? If so, please explain what data was used, and how/why it was shared.

68.1. Not applicable.

Section 5: UKHCDO

69. Please describe your involvement with UKHCDO (including any of its working parties, committees or groups).

69.1. None.

70. During the period you belonged to UKHCDO, please outline any involvement you had in the development of policies or advice by UKHCDO which are relevant to the Inquiry's Terms of Reference and how information or advice was disseminated by the UKHCDO and to whom.

70.1. Not involved. Advice circulated to centres or through Dr. Bloom.

Section 6: Pharmaceutical companies/medical research/clinical trials

71. Have you ever:

a. Provided advice or consultancy services to any pharmaceutical company involved in the manufacture and/or sale of blood products?

b. Received any pecuniary gain in return for performing an advisory/consultancy role for a pharmaceutical company involved in the manufacture of sale of blood products?

c. **Sat on any advisory panel, board, committee or similar body, of any pharmaceutical company involved in the manufacture or sale of blood products?**

d. **Received any financial incentives from pharmaceutical companies to use certain blood products?**

e. **Received any non-financial incentives from pharmaceutical companies to use certain blood products?**

f. **Received any funding to prescribe, supply, administer, recommend, buy or sell any blood product from a pharmaceutical company?**

g. **Undertaken medical research for or on behalf of a pharmaceutical company involved in the manufacture or sale of blood products?**

h. **Provided a pharmaceutical company with results from medical research studies that you have undertaken?**

If so, please provide details.

71.1. No.

72. **What regulations or requirements or guidelines were in place at the time concerning declaratory procedures for involvement with a pharmaceutical company? If you were so involved, did you follow these regulations, requirements and guidelines and what steps did you take?**

72.1. Was not involved, and not aware of the specific regulation.

73. If you did receive funding from pharmaceutical companies for medical research, did you declare the fact that you were receiving funding and the source of the funding to your employing organisation?

73.1. No funding received.

Section 7: Other Issues

74. Please provide details of any complaints made about you (insofar as relevant to the Inquiry's Terms of Reference) to your employer, to the General Medical Council, to the Health Service Ombudsman or to any other body or organisation which has a responsibility to investigate complaints.

74.1. No complaints.

75. Please explain, in as much detail as you are able to, any other matters that you believe may be of relevance to the Infected Blood Inquiry, having regard to its Terms of Reference and to the current List of Issues.

75.1. I have no observations or opinions regarding events which may be of interest or relevance of the current enquiry.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 19th March 2021.